CareSource | NETWORK Notification

Notice Date: August 28, 2026
To: Ohio Medicaid & Ohio MyCare Providers
From: CareSource
Subject: Collecting Additional Information for Laboratory Services
Effective Date: October 1, 2026

Summary
To ensure compliance with Ohio Administrative Code rule 5160-11-11 and related regulations, Managed Care Organizations (MCOs) will require timely and adequate documentation from providers ordering laboratory services. Failure to provide necessary documentation may result in claims being denied or recoupment. Providers should review their records and processes to ensure all documentation is current and accessible when requested.

Impact
This clarification affects all providers who submit claims for laboratory services under Ohio Medicaid managed care plans. It emphasizes the responsibility of ordering providers to maintain appropriate documentation of medical necessity and sets forth the process MCOs will follow to verify this documentation both pre- and post-payment.

Key Information and Requirements:

Documentation Requirements:
- Payment is permitted only for laboratory services deemed medically necessary per Chapter 5160-1 and rule 5160-11-11.
- Ordering physicians must maintain medical records documenting the medical necessity of laboratory tests.
- Providers must comply with prior authorization requirements, especially when exceeding frequency limits.
- Laboratory providers must keep copies of:
  - Written orders for lab procedures,
  - Clinical diagnostic results for consultations or interpretations,
  - Written narrative reports by consulting/interpreting practitioners.
- Laboratory providers may request additional medical information from ordering providers as needed to support billed services, respecting patient confidentiality.

MCE Requests for Additional Information:
When an MCO needs further information related to a lab service, it will request the following from the laboratory provider:
- The order for the service billed,
- Verification of accurate processing of the order and submitted claim,
- Diagnostic or additional medical information provided by the ordering provider.

Pre-Adjudication Claim Review:

- If submitted documentation does not demonstrate medical necessity, the MCO will suspend the claim.
- The MCE will notify the ordering provider with sufficient claim identification details and request relevant parts of the patient's medical record.
- Copies of this request will also be sent to the laboratory provider.
- Providers have at least 45 calendar days to submit requested documentation.
- If documentation is not received, the MCE will inform the lab and deny the claim.
- Denied claims under this process are not considered "clean claims" and do not impact prompt pay rules.

Post-Payment Review:

- Similar to pre-adjudication, if documentation is insufficient, the MCO will request the ordering provider's relevant medical records.
- The ordering provider must respond within 45 calendar days.
- Failure to respond results in a notice of intent to recover overpayments.
- Laboratory providers will be copied on all correspondence.

Claim Denial and Recoupment Requirements:

- MCEs must demonstrate efforts to obtain documentation from ordering providers before denying claims or pursuing recoupments.
- Sampling and extrapolation methods may be applied following the Ohio Department of Medicaid's (ODM) guidance once attempts to obtain documentation have been properly conducted.

Action Required:

Providers are advised to:

- Review and update documentation practices for laboratory orders to ensure compliance.
- Respond promptly to requests from MCEs for medical necessity documentation.
- Coordinate with laboratory providers to maintain accurate and complete documentation.

For additional questions, please contact Provider Services:

- **CareSource Ohio MyCare**: Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET)
- **Medicaid**: Monday through Friday, 7 a.m. to 8 p.m. ET

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